THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-015034
STATE FILE NUMBER

FILED APR 20 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 3175

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN ST. LOUIS, MISSOURI — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Illinois b. COUNTY Lawrence
c. CITY OR TOWN Lawrenceville — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 902 Lexington, St. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First ROBERT Middle KINKADE Last GOULD

4. DATE OF DEATH: Month Day Year MARCH 30, 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] / DIVORCED [ ]
8. DATE OF BIRTH: April 8, 1901
9. AGE (In years last birthday): 57 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Technician
10b. KIND OF BUSINESS OR INDUSTRY: Refrigeration
11. BIRTHPLACE (City and state or country): Lawrence County, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Henry C. Gould
13b. MOTHER'S MAIDEN NAME: Sarah Kinkade
14. NAME OF HUSBAND OR WIFE: Gertrude

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Gertrude Gould, 902 Lexington, Lawrenceville, Ill.

MEDICAL CERTIFICATION — USE ONLY BLACK INK OR RIBBON, TYPEWRITE IF POSSIBLE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Post operative for aortic aneurysm
DUE TO (c) 451X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Aortic aneurysm.
INTERVAL BETWEEN ONSET AND DEATH: 30 hrs.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 3.10 PM 29 March to 6.15 30 March last saw her/him alive on 10 PM 29 March
Death occurred at 6:15 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) William M. D.
22b. ADDRESS BARNES HOSPITAL
22c. DATE SIGNED 3/30/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 4-2-59
23c. NAME OF CEMETERY OR CREMATORY City Cemetery
23d. LOCATION (City, town, or county) (State) Lawrenceville, Ill.

24. FUNERAL DIRECTOR ADDRESS: Albert H. Hoppe 4700, Washington, Blvd.
25. DATE RECD. BY LOCAL REG. MAR 30 '59
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service

. 300 1-57

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~ ...., Student Embalmer No. ....

working under my personal supervision.

Student ....
Signature of Student Embalmer

Signed Ellsworth H. Remelius

Licensed Embalmer No. 4283

P. O. Address St. Louis, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.